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ABSTRACT

This document presents a review of the history of the implementation of de-institutionalization in Queens County, a borough of New York City. A number of issues confronting the mental health profession, the community, the patients, and their families are discussed. It notes that Creedmoor Psychiatric Center, the major provider of services for the severely mentally ill in the Queens County area, now has the largest concentration of former mental patients living in community residences in the state. Events are described beginning in 1970 when the director of Creedmoor matched the needs of the dischargeable patients to the needs of the Rockaway community, a failing beach resort, and, using the talents of the rehabilitation, social work, and nursing staff, created what became the prototype for many of the state's after-care programs. The history of this change is examined against the current needs of the new mentally ill homeless, changing demographics, and political and economic issues. Strategies for intervention, such as the rediscovery of the asylum as a safe harbor for the severely mentally impaired and the use of the "revolving door" or rehospitalization for patients experiencing temporary stress, are discussed. New models of caregiving are proposed, including hybrid services for the dischargeable, but non-placeable patients. (Author/NB)

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DE-INSTITUTIONALIZATION: THE QUEENS EXPERIENCE

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Anne Wyden, Treatment Team Leader, the pioneer who went into the community in the early 1970's, with no guidelines at all, created models for all of us; she continues to contribute her energy to programs for the chronically mentally ill as Treatment Team Leader at Creedmoor Psychiaric Center. She has given generously to this project by sharing her files and her knowledge.

H.D.P.

September 30, 1986

ABSTRACT

De-Institutionalization: The Queens Experience

Creedmoor Psychiatric Center, located in the Borough of Queens, New York City, now has the largest concentration of former mental patients living in community residences in the state.

In 1970, a newly appointed Director matched the needs of the dischargeable patients to the needs of the Rockaway community, a failing beach resort, and, using the talent of the rehabilitation, social work and nursing staff, created what became the prototype for many of the State's after-care programs.

The history of this change is examined against the current needs of the new mentally ill homeless, changing demographics and political and economic issues. Solutions to these challenging problems are considered: the rediscovery of the asylum and the worthiness of the revolving door.

New models of care-giving are proposed including hybrid services for the dischargeable, but non-placeable patients.

DE-INSTITUTIONALIZATION: THE QUEENS EXPERIENCE

INTRODUCTION

On May 1, 1986, more than twenty years after the social policy called "de-institutionalization" was prescribed as the treatment of choice against the damaging effects of mental hospital living on the mentally ill, Marty Goldenson, narrator of PBS CURRENTS television documentary "Not in My Neighborhood", asked the question: "Is de-instituionalization a good idea to improve on, or a bad idea to scrap?" On that broadcast, Thomas Liguori, a mental health advocate, said, "(discharge from the institution) was not decided medically; it was decided socially."

It will probably be another twenty years before there can be a reasonable assessment of this policy, when data on the life histories of those patients entering the system after implementation can be compared to the life histories of those who preceded them. In order to understand the impact of this policy, it is important to understand its historical context. A review of the history of the implementation of de-institutionalization in Queens County, a borough of New York City, illuminates a number of the issues confronting the profession, the community, the patients and their families.

Queens County is far from typical because of the enormous number of former mental patients living in various community residential settings. The January, 1986 Housing Unit Data report 3.112 clients, probably the largest concentration in any community in the United States.[1] Because of its large scale, Queens provides a model for study.

THE QUEENS EXPERIENCE

If Queens County were a city, its two million population would rank as the tenth largest city in the United States. The major provider of services for the severely mentally ill in the area is Creedmoor Psychiatric Center, the facility where Sylvia Frumkin, the patient portrayed by Susan Sheehan in her Pulitzer Prize winning work, IS THERE NO PLACE ON EARTH FOR ME?[2] spent most of her adult life.

Creedmoor, in 1956, reached its highest census: 6018, nearly 45% above its certified capacity of 4,188. That is the year when the so-called wonder drugs came into general use. While the population in all of the New York State psychiatric hospitals decreased from a high of 92,862 in 1956 to 27,866 in 1978, Creedmoor's decrease during that time was only 314 to a census of 5,704. This modest change was due principally to the conservative style of its leadership which faithfully reflected the conservative climate of the surrounding community made up of middle/middle class residents who, in their escape from difficult inner city life through hard work, had established tight ethnic neighborhoods.

Mandatory retirement in 1969 of the Director, Dr. Harry LaBurt, after 25 years of service, led to the appointment of a charismatic, radical leader, Dr. Irwin Greenberg, who operationalized his commitment to the belief that mental hospitals are hazardous to one's mental health, by implementing a bold reorganization plan. On one day in March, 1970, all 5704 patients were moved from wards where they had been placed, categorized by length of stay and management criteria, to wards representing the 12 health planning districts* of Queens County,

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* There are now 9 health planning districts designated by HSA.

according to their home addresses. Right after breakfast, the patients placed their belonging into pillow cases, and before the noon meal, they were in their new ards. It was not a smooth operation: there were patients without charts, charts without patients, staff without assignments, but, somehow, no one was lost permanently, and within a month, things were pretty much sorted out.

Each Unit, as the geographic areas were called, had its Chief and operated in a semi-autonomous fashion, admitting patients from its catchment area, setting up networks of after-care clinics and developing linkages with community agencies. Continuity of care, decentralization of decision-making and treatment in the least restrictive setting were guiding principles. In the three years following this dramatic change, the census declined from 5,704 to 2,943. During these three years, the out-patient census went from zero to 3000.

Depopulation of the wards allowed consolidation and the closing of several buildings with a corresponding increase in the staff/patient ratio. Staff were free now to work in the community. Families, who had all but abandoned their patients, were brought back to become reacquainted with their relatives; new family relationships were established.

While the Director was convinced that the hospital fostered dependence, efforts continued to make the hospital as therapeutic a setting as possible while great energy was invested in getting as many patients into the community as possible. Within a year after "unitization", and the rapid discharge of hundreds of patients, the social workers were beginning to find that there were just no more rooming houses in Queens for placement. The solution to the housing problem was found in the Rockaway Peninsula, an 11 mile strip of land, fronted on the south by the Atlantic Ocean and on the north by Jamaica Bay.[3]

For many years, Rockaway's 140,000 population was augmented during the summer months by about 60,000 vacationers who occupied the hotels along the beaches. The community lost its fashionable role as the rich fled to the Hamptons, leaving most of the hotels almost empty.[4] The owners of these facilities tried several strategies to improve their business. They advertised their places as retirement homes, but many were still empty. In desperation, the proprietors branched out, making room available to elderly ex-mental patients, but, still, did not fill their rooms.

In a happy convergence of needs, space for the younger patients ready for community placement became available as the proprietors accepted those suitable for placement. A the beginning, in the early '70's, in what now looks like the age of innocence, the proprietors would come onto the wards and point out to the staff those patients they wanted for their homes. It was screening in its crudest form: proprietors wanted docile people. Extra consideration was given to those who were also female non-smokers.

This business became so profitable that, as the old structures were filled, entrepreneurs built new structures to serve as adult homes. By August, 1977, there were a total of 12 homes in the Rockaways, with a total population of 1,035, most of them former mental patients. Fewer than half of these came from Creedmoor, the rest having been placed by 3 large state hospitals on Long Island, 4 in New York City and several in upstate counties.

Although more than half of New York State's discharged mental patients living in adult homes were placed in Queens County, no funds had been allocated for their care. A voluntary agency, Catholic Charities, had a small program, three teams, each with a psychiatrist, nurse and social worker, each team assigned to 3 homes. They worked hard in a

struggle against the demands of an ever rising number of clients.

The Rockaway community, already suffering from blight, was beginning to raise concerns about "impaction" as the patients became a visible and unpleasant presence. The new Director of Creedmoor, the late William L. Werner, was particularly sensitive to these changes because he had grown up there, and before entering the field of psychiatry, had a successful medical practice in the area. He was approached in 1974 by a staff occupational therapist, Anne Wyden, who had worked with the Catholic Charities Mental Health Clinic for a year, before retunring to Creedmoor where she had done her student internship. Wyden was interested in a change of assignment, and suggested to Dr. Werner that he review the problems in the Rockaway area, Wyden pointed out that she saw a two class system of care for the mentally ill there: the patients who came to the clinic from home, never having been hospitalized, got first class psychiatric care; i.e., individual interviews with psychiatrists, individual therapy, etc. The clients in the adult homes, older, chronically mentally ill from state hospitals, were seen in large groups by paraprofessionals from Creedmoor, part of a shared staff program. These patients, long abandoned by their families and friends, came to the monthly groups and were handed packets of medication. If they did not come, they did not come. There was no tracking, no follow-up.

Wyden had worked in the Day Program during her year at the Charities Mental Health Center. She would travel between Creedmoor and the Rockaway Clinic as part of the community preparation programs for in-patients. She followed the then common practice: gather the patients in the hospital into a group and get them to talk about their feelings about discharge. None of the 12 assigned patients talked. She found sitting in silence intolerable, so she decided to plan a community acti-

vity, a trip to a local super market. She was in for several surprises. The patients needed to be reminded about safety measures while crossing the street. They had never shopped in a super market. They did not know how to check out their purchases. Wyden quickly realized that getting the patients out would be a process, not an event. She set out a curriculum of tasks, breaking each task into its component parts, and taught the patients the activities in planned sequences.

Once a month, she took patients in the group to lunch in one of the adult homes. To deal with resistance expressed by the patients about moving away from Creedmoor, she began telling these long-term patients, "Remember what Creedmoor used to be like when it was good? It's not like than any more, so it's not a good place to be." Wyden said that it was difficult, but eventually she got all 12 of the patients to hate Creedmoor. It took a year, but she was able to place all 12, in pairs, in adult homes. She kept her promise to visit the patients after they were placed, and brought the patients not yet ready for discharge with her so that they could see that their friends were doing well.

When Dr. Werner and Wyden reviewed the problems together, he agreed that there was a need to set up a program in the Rockaways for the rapidly growing number of clients. Wyden's joy at his interest was short-lived when she learned that the plan was to assign 8 para-professionals to work with her, one in each of the homes then operating.

Wyden had other ideas. She started with one full month of training for the staff. She taught the paraprofessionals how to evaluate the client's skills, how to break activities down into their component parts and how to teach these basic skills. She showed the staff the W.C. Fields' film, "If I Had a Million." In this 1930's farce, a name is picked out of the phone directory to receive a million dollars. In one episode, the

recipient is a resident of a nursing home where the staff keep the place spotless, and force all of the residents to sit all day in rocking chairs, doing nothing. When the gentleman resident receives his money, he buys the home, gets the residents involved in all kinds of activities, and forces the staff to sit all day in rocking chairs. Wyden explained to her staff, "We're going to do that for our clients. It's as if we got a million dollars."

Wyden placed two worker teams in four of the eight homes. The first year after the program was put into place, rehospitalization of the adult home groups was reduced by 80%. Activity programs were used to establish contact with the residents to allow for monitoring of their mental state, their general health and the development of trust so that when problems came up, the residents would use the home workers to help them.

Wyden convinced the proprietors that they were really fortunate to have the teams, that not every home would be so lucky. At the same time, some unwise, or even fraudulant practices were uncovered, and there were many times that the Social Services Department had to intervene to stop admissions in order to have abuses corrected.

The program grew. Nurses and social workers were added to the team As new homes opened up, the community became even more irate. By 1978, dumping became a major political campaign issure for Governor Carey's re-election. The TV film, "Back Wards to Back Streets", newspaper articles, etc., were being used to illustrate the lack of responsible planning by the State Office of Mental Health. The governor's team mobilized to deal with the problem. Chapter 620 of the New York State laws mandated that the State provide services for any patient who had been in

a state hospital 5 years or longer on November 1, 1978, no matter where the patient was placed. The was to help patients placed after that date, but did nothing at all for the more than 1000 patients already living in the community. It was not until 1979 that monies were allocated for this group through Community Support System funds.

The political problems created by the way in which the CSS funds were awarded almost created a civil war because the funds were to go to the voluntary agencies. The New York State employee unions objected, saying that this would result in massive lay-offs. The Morgado Agreement was designed to protect the jobs of New York State employees who were to be offered the jobs created by these funds; training funds were allocated to re-train state workers to take on new roles.

The voluntary agencies have taken on the care of the discharged patients, and have proven themselves effective in many areas. Their low salaries have made their jobs less attractive to state workers who also have far more liberal fringe benefits. Therefore, very few state employees moved out of the system into the private sector.

PRESENT PROBLEMS

Three major probelms now confront the profession:

First, the problem of homelessness has become a national scandal, and there is no question that many of the homeless are also mentally disabled. Civil libertarians and patient advocates insist that the patients be free to decide their fate unless there is compelling evidence that that individual is a danger to himself or others.

Second, the population who must remain hospitalized are becoming more and more difficult to work with because of the severity of their psychopathology, multiple disabilities, and, frequently, dangerousness and a history of criminal behavior. Many have chronic and serious mental pro-

blems, cognitive deficits and a history of failed treatment, all factors which contribute to staff burn-out.

The third problem impacts on both the in and out-patient settings: the young, adult chronic, with a history of mental illness, substance abuse and violence. These patients prey on other patients and staff in the hospital and on society when they are in the community, for selfish gain. They can only be held in state hospitals during an acute episode. Preventive detention, while tempting, is anathema in our free society. Treatment strategies are notoriously unsuccessful. In prison, they are often the victims of their fellow-inmates. At the present time, this group is causing major problems in community residences. A New York City study, based on 1985 data, indicates that over 30% of community residents have a history of serious behavior problems (physical assault, destruction of property, etc.), 42% a history of substance abuse (alcohol or drugs in the 30 days prior to the survey, or current diagnosis of alcohol or drug abuse) and 57.9% both serious behavior problems and substance abuse.[5] (See Appendix, Table II).

STRATEGIES FOR INTERVENTION

Queens County has some small demonstration programs designed to deal with this most difficult group, but the problems will not be easily solved. Cooperation with local law enforcement officials and with the courts is an important component. Change in policy to provide involuntary extended treatment in a secure hospital setting could protect society from the patient and the patient from his self-destructive course.

The rediscovery of the asylum, and the role it plays in providing safe harbor for the severely impaired is another important strategy for assuring care and service. Programs to prevent staff burn-out as they work with everyone's treatment failures is crucial to success in work-

ing with both the severely impaired and the dischargeable, but non-placeable patient. Quality assurance programs, designed to assure treatment which meets standards for care, must be scrutinized in order to make certain that these efforts do not contribute to a sense of failure and futility when inappropriate standards are applied.

The programs which Wyden and her teams set up, starting in 1974, have served as a model for Community Support System programs throughout the State. They continue to serve the needs of the community residence population and to prevent re-hospitalization. Readmissions for over 2000 mentally disabled clients in Queens remain at 5-8 per month. Borough-wide screening for the 17 adult homes by Catholic Charities professionals must be considered as a major factor in keeping this figure so low.

Several new models for care (supportive apartments, transitional services, intensive supportive and supervised living) augment the adult homes and provide different levels of community care. Crisis beds, night hospital and day hospital are essential components in provision of community services.

Among several problems is the vexing question of how to bestow incentives to providers who work to move their clients into less restrictive settings. After all, from the point of view of a provider, they lose their "best" clients, and accept, in their places, more severely impaired people. Some form of utilization review may be in order, but such a program could back-fire, making even more difficult development of suitable community placements.

The in-patient census, today, at Creedmoor, is between 1240 and 1275 in spite of the fact that there are nearly 3000 admissions annually.

Most of the admissions are re-admissions; relapses of the chronically mentally ill. All research seems to indicate that it is the quality of housing which is the most critical factor in maintaining patients in the community. In addition, it becomes increasingly clear that the total cost of maintaining patients in the community may be at least as much as warehousing patients in the asylum. This suggests that society, in making spending choices, will have to acknowledge the value of independent community living for the chronically mentally ill, a concept addressed in a paper by Jack A. Franklin, et. al.[6,7]

Prudent use of the "revolving door", i.e., re-hospitalization for patients in need of a "pit stop" (as Sylvia Frumkin called in when re-hospitalized in fall, 1985) provides a sense of security and sanctuary in times of stress.

For the dischargeable, but non-placeable patient (i.e., those with a history of fire-setting, multiple placement failures, criminal records, vagrancy, poor compliance, etc.), Residential Care Centers for Adults, opening up on the grounds of psychiatric centers as quarter-way houses, offer promise.

CREEDMOOR PSYCHIATRIC CENTER-COMMUNITY LIVING UNIT

January, 1986

	# BEDS CERT	#BEDS VAC	PLACED FROM CPC	PLACED FROM LEVEL OF CARE	SCREEN INGS	#CPC REHOSP	TOTAL #DISCH CPC PTS IN All	#PTS. ON CPC CENSUS	CURRENT CENSUS
CREEDMOOR AFTERCARE									
CHAI	71	2	1	1	1	1	34	37	69
HI LI	125	4	0	0	1	1	49	59	121
NEW HAVEN	123	2	2	1	3	1	25	13	121
PARK INN	181	5	3	2	8	1	76	51	176
QUEEN ESTHER	47	1	0	0	0	0	16	7	46
ROCKAWAY MANOR	120	3	2	2	7	0	51	62	117
SEAVIEW	124	2	0	0	0	0	40	49	122
SEVILLE	55	5	0	0	1	0	13	27	50
WAVECREST	120	4	2	1	3	2	71	39	116
TOTALS	966	28	10	7	24	6	377	344	938
PRIVATE AFTERCARE									
CENTRAL MANOR	186	3	0	0	4	1	154	0	183
ELM YORK	286	6	1	1	1	0	195	0	200
LEBEN	360	10	1	0	7	1	181	0	350
NEW WHITMAN	240	20	1	0	0	2	85	0	220
QUEENS MANOR	264	10	1	1	6	1	82	0	252
SHALOM	125	5	0	0	2	0	89	0	120
SANFORD	190	3	0	0	1	0	53	0	187
SURFSIDE	200	1	0	0	1	0	38	0	199
TOTALS	1851	58	4	2	22	5	777	0	1793
GRAND TOTALS	2817	86	14	9	46	11	1154	344	2731

APPENDIX - TABLE I

NEW YORK CITY REGIONAL "CR PROFILE" INPATIENTS WHO HAVE
HISTORIES OF SERIOUS BEHAVIOR PROBLEMS OR SUBSTANCE ABUSE

January 6, 1986

Facility	1. History of Serious Behavior Problems		2. History of Substance Abuse		3. History of 1 or 2		CR Pool	
	N	% of CR Pool	N	% of CR Pool	N	% of CR Pool	N	% of CR Pool
Kingsboro	132	31.9%	254	44.5%	337	59.0%	571	100%
Creedmoor	241	32.4%	230	30.9%	375	50.4%	744	100%
Manhattan	250	30.5%	471	57.4%	553	67.4%	820	100%
Bronx	125	24.3%	184	35.7%	266	51.7%	515	100%
South Beach	119	42.0%	93	32.9%	168	59.4%	283	100%
	917	31.3%	1232	42.0%	1699	57.9%	2933	100%

1. Serious behavior problems include: physical assault, destruction of furniture, other violent behavior, or receipt of emergency psychiatric management for violent behavior in the 30 days previous to the survey.

2. Substance abuse is defined as: abuse of alcohol or drugs in the 30 days previous to the survey, alcohol or drug abuse identified at admission, or current diagnosis of alcohol or drug abuse.

Population surveyed: under 65, voluntary admission, or under civil commitment; limited medical needs, good ADL skills; appropriate for community placement.

APPENDIX - TABLE II

REFERENCES

1. Creedmoor Psychiatric Center Community Living Report, January, 1986. See Appendix, Table 1.

2. Sheehan, Susan. IS THERE NO PLACE ON EARTH FOR ME? Vintage Books, A Division of Random House, New York 1983.

3. Werner, William, M.D. and Anne Wyden. Unpublished paper on the development of the adult home program in the Rockaways, 1977.

4. "A Faded Summer Place with Hopes of Revival." NEW YORK TIMES, May 26, 1986, page 21.

5. New York City Regional "CR Profile" Inpatients who have Histories of Serious Behavior Problems or Substance Abuse Unpublished Report by the Evaluation Research Unit of the New York City Regional Office of the New York State Office of Mental Health, January 6, 1986. See Appendix, Table 2.

6. Bisogno, JoAnn, Marhory Braren, Robert Indalls, et.al. "The Public Cost of Treating the Chronically Mentally Ill in the Community. RIPPLE. New York State Office of Mental Health, Bureau of Program Evaluation, October, 1979.

7. Franklin, Jack L., Brenda Solovitz, Jane Simmons. "Quality of Life of the Chronically Mentally Ill". Unpublished manuscript of paper presented at the Annual Meeting of the American Public Health Association, Anaheim California, November 11-16, 1984.